Project 2020:
Potential Cost Offsets

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by
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The Project 2020 proposal will provide incentive grants to states to implement three specific strategies for redirecting their systems of long-term care to make their systems more consumer responsive and more focused on home-and community based services. These changes will:

- Empower consumers to make informed decisions about their care options;
- Help consumers adopt behavior changes that will reduce their risk of disease, disability and injury; and,
- Divert people away from nursing home care

The three components of Project 2020 – Single Entry Points, Evidenced-Based Healthy Living, and a Nursing Home Diversion program -- build upon existing initiatives funded by the Department of Health and Human Services that were launched as part of the President's New Freedom Initiative and the Administration's policy to increase opportunities for Prevention. They were codified in the 2006 Reauthorization of the Older American's Act.

The three components are interrelated and work together to target both individuals at risk of high public expenditures (e.g., those in need of nursing home care, likely to fall, or who have chronic diseases) and those who should be planning for potential future long term care needs (individuals age 40 to 70). The three components will be brought up-to-scale nationwide over ten years in a way that promotes continual program improvements through on-going evaluation based on measurable outcomes and performance standards These measures will be established by HHS and are likely to include consumer health status and reductions in health care utilization (nursing home and hospital stays).

This paper provides details regarding each of the program components and the potential cost offsets. All in all, the savings to Medicare and Medicaid as a result of the effective implementation of the components of the Project 2020 would likely more than offset the cost of the program.

Overall Assumptions on Program Implementation

Project 2020 will be implemented through competitive grants targeted initially at states best positioned to advance the three system change components noted above. Support for the components will increase incrementally each year.

Federal Allocation of Project 2020 Program Funding by Component

Fiscal Year	Single Entry Point	Evidence-based Programs	Nursing Home Diversion	Subtotal Direct Services	Federal Funding to Non-Admin	Administration, Evaluation, and Technical Assistance	Total
FY2010	$30,900,000	$36,050,000	$111,825,137	$147,875,137	$178,775,137	$31,548,554	$210,323,691
FY2011	$38,264,500	$41,200,000	$337,525,753	$378,725,753	$416,990,253	$73,586,515	$490,576,768
FY2012	$48,410,000	$56,650,000	$650,098,349	$706,748,349	$755,158,349	$90,957,448	$846,115,797
FY2013	$53,560,000	$77,250,000	$865,801,631	$943,051,631	$996,611,631	$120,040,056	$1,116,651,687
FY2014	$63,860,000	$92,700,000	$988,504,887	$1,081,204,887	$1,145,064,887	$137,920,981	$1,282,985,867
FY2015	$69,010,000	$103,000,000	$1,124,547,250	$1,227,547,250	$1,296,557,250	$156,167,960	$1,452,725,210
FY2016	$74,160,000	$118,450,000	$1,276,750,865	$1,395,200,865	$1,469,360,865	$176,981,841	$1,646,342,706
FY2017	$79,310,000	$133,900,000	$1,364,488,901	$1,498,388,901	$1,577,698,901	$190,030,960	$1,767,729,861
FY2018	$84,460,000	$149,350,000	$1,466,769,052	$1,616,119,052	$1,700,579,052	$204,831,651	$1,905,410,702
FY2019	$89,610,000	$157,590,000	$1,587,080,097	$1,744,670,097	$1,834,280,097	$220,935,698	$2,055,215,795
FY2020	$95,790,000	$173,040,000	$1,712,755,702	$1,885,795,702	$1,981,585,702	$238,678,390	$2,220,264,091
5 years	$234,994,500	$303,850,000	$2,953,755,756	$3,257,605,756	$3,492,600,256	$454,053,554	$3,946,653,811
10 years	$631,544,500	$966,140,000	$9,773,391,921	$10,739,531,921	$11,371,076,421	$1,403,001,664	$12,774,078,085
2019 % of Total	5%	8%	77%	84%	89%	11%	100%

Amounts Available to States Inclusive of the State Match

Fiscal Year	Single Entry Point	Evidence-based Programs	Nursing Home Diversion	Subtotal Direct Services	Federal Funding to Non-Admin	Administration, Evaluation, and Technical Assistance	Total
FY2010	$41,200,000	$42,411,765	$184,022,344	$226,434,109	$267,634,109	$47,229,549	$314,863,658
FY2011	$51,019,333	$48,470,588	$547,957,824	$596,428,413	$647,447,746	$114,255,485	$761,703,230
FY2012	$64,546,667	$66,647,059	$1,049,036,104	$1,115,683,163	$1,180,229,830	$142,156,534	$1,322,386,364
FY2013	$71,413,333	$90,882,353	$1,389,122,890	$1,480,005,243	$1,551,418,576	$186,865,543	$1,738,284,119
FY2014	$85,146,667	$109,058,824	$1,583,248,655	$1,692,307,478	$1,777,454,145	$214,091,116	$1,991,545,261
FY2015	$92,013,333	$121,176,471	$1,798,422,237	$1,919,598,707	$2,011,612,041	$242,295,008	$2,253,907,048
FY2016	$98,880,000	$139,352,941	$2,039,117,396	$2,178,470,337	$2,277,350,337	$274,302,702	$2,551,653,038
FY2017	$105,746,667	$157,529,412	$2,179,245,090	$2,336,774,502	$2,442,521,168	$294,197,228	$2,736,718,396
FY2018	$112,613,333	$175,705,882	$2,342,598,208	$2,518,304,091	$2,630,917,424	$316,889,214	$2,947,806,638
FY2019	$119,480,000	$185,400,000	$2,534,748,730	$2,720,148,730	$2,839,628,730	$342,028,110	$3,181,656,841
FY2020	$127,720,000	$203,576,471	$2,735,467,068	$2,939,043,539	$3,066,763,539	$369,386,084	$3,436,149,623
5 years	$313,326,000	$357,470,588	$4,753,387,818	$5,110,858,406	$5,424,184,406	$704,598,226	$6,128,782,632
10 years	$842,059,333	$1,136,635,294	$15,647,519,479	$16,784,154,773	$17,626,214,106	$2,174,310,486	$19,800,524,593

Allocations for Administration, Evaluation and Technical Assistance

Fiscal Year	AAA	SUA	AoA	Evaluation/TA	Administration, Evaluation & Technical Assistance
FY2010	$16,825,895	$8,412,948	$2,103,237	$4,206,474	$31,548,554
FY2011	$39,246,141	$19,623,071	$4,905,768	$9,811,535	$73,586,515
FY2012	$50,766,948	$25,383,474	$6,345,868	$8,461,158	$90,957,448
FY2013	$66,999,101	$33,499,551	$8,374,888	$11,166,517	$120,040,056
FY2014	$76,979,152	$38,489,576	$9,622,394	$12,829,859	$137,920,981
FY2015	$87,163,513	$43,581,756	$10,895,439	$14,527,252	$156,167,960
FY2016	$98,780,562	$49,390,281	$12,347,570	$16,463,427	$176,981,841
FY2017	$106,063,792	$53,031,896	$13,257,974	$17,677,299	$190,030,960
FY2018	$114,324,642	$57,162,321	$14,290,580	$19,054,107	$204,831,651
FY2019	$123,312,948	$61,656,474	$15,414,118	$20,552,158	$220,935,698
FY2020	$133,215,845	$66,607,923	$16,651,981	$22,202,641	$238,678,390
5 years	$250,817,238	$125,408,619	$31,352,155	$46,475,543	$454,053,554
10 years	$780,462,694	$390,231,347	$97,557,837	$134,749,785	$1,403,001,664

Estimated Number of Grants Each Year By Component (includes territories and tribal lands)

Fiscal Year	Single Entry Point	Evidence Based Programs	Nursing Home Diversion
2010	All	All	17
2011	All	All	34
2012	All	All	51
2013	All	All	51
2014	All	All	51
2015	All	All	51
2016	All	All	51
2017	All	All	51
2018	All	All	51
2019	All	All	51
2020	All	All	51

All includes all states, territories and tribal lands.

51 includes the 50 states and the District of Columbia.

Project 2020 will require states to match 25 percent of the total funding (33 percent of the federal funding) for Single Entry Points, and 15 percent of the total funding (18 percent of the federal funding) for Evidence-Based Health Living. The Nursing Home Diversion component would use an enhanced Medicaid federal matching assistance percentage (FMAP) that adds five percentage points to the federal share. Nearly 90 percent of the federal funding will be used to support consumer information and services; remaining federal funding will be devoted to supporting program administration (federal, state and local), evaluation, and a technical assistance component to help ensure consistent and effective implementation to bring several proven and inter-related programs up to a national scale. A strong evaluation and technical assistance component will be required to ensure the program is implemented at the state and local level in a way that is consistent with the federal design, performance expectations and standards which will be necessary to ensure achievement of the program outcomes related to health status and reductions in the utilization of health care including nursing home and hospital stays.

Potential Budget Offsets

The successful implementation of the combination of the three components presents a strong potential for budget offsets resulting in the program's total cost offset, particularly over the longer term. The Single Entry Point component enables the other components to function and the overall Project 2020 will increase client satisfaction and result in long term efficiencies and economies for the clients and the state and federal governments. The assumptions and results for each component's potential budget offsets are presented in detail following the summary on the next page.

Single Entry Point Assumptions

- **Program:** Single Entry Point (SEP) consists of streamlining access to public and private services like Aging and Disability Resource Centers (ADRC). This component will provide assistance, access, and awareness of long-term care services and supports, including OAA programs, Medicaid, state-funded programs and the availability of other services, as well as the necessary infrastructure to implement the components of Project 2020. As part of ongoing multi-agency information campaigns, the OAA providers can encourage elders to consider LTC options that better meet their needs and wishes – and that conserve both personal and public resources. SEPs become the referral source to provide:
  - information about long-term care planning and services available through a variety of media (website, seminars, pamphlets, etc.);
  - assistance with making difficult decisions about long-term care and determining the most appropriate services through options counseling, futures planning, and care management;
  - streamlined access to public long-term care benefits (mandatory for both Medicaid nursing home and home and community-based services (HCBS), as well as OAA HCBS benefits) through efforts to shorten and simplify the eligibility process for consumers;
  - the allocation of the funds available under the Nursing Home Diversion portion of Project 2020; and
  - links to Evidence-Based Health Promotion programs.
- **Timeframe:** The funding rolls out from 2010 to 2020 at the indicated levels.
- **States Funded:** The 43 existing ADRC grantees and remaining 10 states, territories, and tribal lands would receive funding annually, beginning in 2010.
- **Allocation of Implementation Funding**: In 2010-2011, grantees would receive on average $542,105 annually. All states and the District of Columbia would receive a fixed amount of $309,000 in funding in 2010 to cover necessary infrastructure development and maintenance. The territories and tribal lands would have a pool of $1.96 million to be allocated among them. The fixed amounts would inflate based on inflation annually (assumed to be 3% for the estimates).[1] All 50 states, the District of Columbia, and Puerto Rico would receive an additional allotment based on their relative share of the total U.S. population aged 60+ and below age 65 with disabilities to account for the relative differences in the demand as a result of the size of their population.
- **State Match**: 25 percent of the total funding or 33 percent of the federal funding.
- **Target Population**: Age 60+ and all populations with disabilities

[1] Although these programs tend to be primarily labor intensive, we used inflation rather than wages because the Bureau of Labor Statistics' National Industry-Specific Occupational Employment and Wage Estimates for NAICS Industry 624120 - Services for the Elderly and Persons with Disabilities for social workers and social and human services assistants shows that between 2004 and 2007 wages increased at about or less than the rate of inflation.

Summary of Potential Federal Budget Offsets

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Summary 2009-2013	Summary 2009-2018
Single Entry Point													
Federal Budget Authority (in thousands)	$30,900	$38,265	$48,410	$53,560	$63,860	$69,010	$74,160	$79,310	$84,460	$89,610	$95,790	$234,995	$631,545
Federal Grant Outlays (in thousands)	$20,085	$35,687	$44,859	$51,758	$60,255	$67,208	$72,358	$77,507	$82,657	$87,808	$93,627	$212,644	$600,181
Number of States, Territories & Tribal Lands	All	All	All	All	All	All	All	All	All	All	All		
Proportion of Population with ADRC	28%	42%	59%	79%	100%	100%	100%	100%	100%	100%	100%		
Total Contacts (in mill.)	3.8	5.4	7.5	10.1	12.8	12.9	13.0	13.1	13.3	13.4	13.5	40	105
Total Screens (in thousands)	246.3	350.4	488.8	654.0	833.0	840.1	847.2	854.3	861.4	868.5	875.6	2,573	6,844
Total Diversions (in thousands)	3.7	5.3	7.3	9.8	12.5	12.6	12.7	12.8	12.9	13.0	13.1	39	103
Total Federal Offsets (in thousands)	-$34,501	-$69,675	-$100,697	-$140,891	-$189,296	-$214,996	-$220,329	-$229,271	-$242,580	-$256,640	-$271,493	-$535,060	-$1,698,875
Total Federal Net Change (in thousands)	-$14,416	-$33,988	-$55,838	-$89,134	-$129,041	-$147,789	-$147,972	-$151,763	-$159,922	-$168,832	-$177,866	-$322,416	-$1,098,694
Evidence Based Programs													
Federal Budget Authority (in thousands)	$36,050	$41,200	$56,650	$77,250	$92,700	$103,000	$118,450	$133,900	$149,350	$157,590	$173,040	$303,850	$966,140
Federal Grant Outlays (in thousands)	$9,013	$37,338	$45,063	$61,800	$81,113	$95,275	$106,863	$122,313	$137,763	$151,410	$161,453	$234,325	$847,948
Number of States, Territories & Tribal Lands	All	All	All	All	All	All	All	All	All	All	All		
Total Completers	38,482	154,781	181,364	241,483	307,715	350,915	382,130	424,639	464,347	495,483	512,958	923,824	3,041,339
Total Federal Offsets (in thousands)	-$14,326	-$60,501	-$74,284	-$104,067	-$139,240	-$166,728	-$190,637	-$222,436	-$255,397	-$286,149	-$311,053	-$392,418	-$1,513,765
Total Federal Net Change (in thousands)	-$5,313	-$23,164	-$29,221	-$42,267	-$58,128	-$71,453	-$83,774	-$100,123	-$117,635	-$134,739	-$149,600	-$158,093	-$665,817
Nursing Home Diversion													
Federal Budget Authority (in thousands)	$111,825	$337,526	$650,098	$865,802	$988,505	$1,124,547	$1,276,751	$1,364,489	$1,466,769	$1,587,080	$1,712,756	$2,953,756	$9,773,392
Federal Grant Outlays (in thousands)	$0	$83,869	$281,101	$571,955	$811,876	$957,829	$1,090,537	$1,238,700	$1,342,554	$1,441,199	$1,557,002	$1,748,800	$7,819,620
Number of States, Territories & Tribal Lands	17	34	51	51	51	51	51	51	51	51	51		
Total Participants	0	15,216	47,981	92,374	124,196	139,199	150,703	162,803	167,999	171,755	176,720	279,766	1,072,224
Total Diversions	0	4,260	13,435	25,865	34,775	38,976	42,197	45,585	47,040	48,091	49,482	78,334	300,223
Total Federal Offsets (in thousands)	$0	-$87,976	-$296,152	-$607,879	-$868,560	-$1,030,256	-$1,178,603	-$1,344,319	-$1,458,362	-$1,565,516	-$1,691,308	-$1,860,568	-$8,437,623
Total Federal Net Change (in thousands)	$0	-$4,107	-$15,052	-$35,924	-$56,684	-$72,426	-$88,067	-$105,619	-$115,808	-$124,317	-$134,306	-$111,767	-$618,004
Administration, Technical Assistance and Evaluation													
Federal Budget Authority (in thousands)	$31,549	$73,587	$90,957	$120,040	$137,921	$156,168	$176,982	$190,031	$204,832	$220,936	$238,678	$454,054	$1,403,002
Federal Grant Outlays (in thousands)	$7,887	$42,058	$77,929	$98,228	$124,510	$142,483	$161,371	$180,244	$193,731	$208,858	$225,371	$350,613	$1,237,300
Total Federal Budget Authority (in thousands)	$210,324	$490,577	$846,116	$1,116,652	$1,282,986	$1,452,725	$1,646,343	$1,767,730	$1,905,411	$2,055,216	$2,220,264	$3,946,654	$12,774,078
Total Federal Outlays (in thousands)	$36,985	$198,951	$448,951	$783,741	$1,077,754	$1,262,794	$1,431,128	$1,618,764	$1,756,706	$1,889,274	$2,037,453	$2,546,382	$10,505,048
Total Federal Offsets (in thousands)	-$48,827	-$218,152	-$471,133	-$852,838	-$1,197,096	-$1,411,979	-$1,589,569	-$1,796,025	-$1,956,339	-$2,108,304	-$2,273,854	-$2,788,046	-$11,650,263
Net Federal (in thousands)	-$11,842	-$19,201	-$22,181	-$69,097	-$119,343	-$149,185	-$158,441	-$177,261	-$199,633	-$219,030	-$236,401	-$241,664	-$1,145,215

- **Program Costs**:
  - SEP Infrastructure – Grant funding to support SEPs provides incentives to increase the efficient use of existing resources already "in the system" at the state and local level being expended on client information, assistance, client intake, assessment, eligibility determination, on-going case management, client tracking and information management. SEPs nationwide are estimated to require approximately $2.3 billion in 2012 to be fully funded. This estimate is based upon the average cost per ADRC of approximately $3.0 million in 2007.[2] The per SEP cost of the program is assumed to escalate three percent annually. The grants would cover approximately three percent of the total funding needed. Several other sources of funding would also transfer over to the SEPs, including a portion of OAA funds and current Medicaid screening funding. New state general revenue funding could also be required. Several states have demonstrated a clear willingness to provide this needed revenue – Florida, Michigan, and Wisconsin all passed legislation for statewide implementation that included funding; Georgia, Guam, Hawaii, Kentucky, Maryland, New Hampshire, New York, West Virginia and Virginia allocated state funds to their efforts; and Washington state built infrastructure similar to ADRCs using a combination of Medicaid and state general revenue funding.
  - Budget Outlays – Due to the timing of issuing a grant solicitation and awarding funding, federal budget outlays for 2010 are expected to be 65 percent of the budget authority. In 2011, the remaining 35 percent of the 2010 funding plus 65 percent of the 2011 budget authority would become budget outlays. In subsequent years, there would be a 35 percent lag between budget authority and outlays.
- **Population Reached**: The number of individuals who would contact the SEP for assistance is dependent on the percentage of the state covered by SEPs. In 2010, new grantees would not be expected to have any coverage and existing grantees would increase their current ADRC coverage by 10 percentage points or a minimum of 10 percent statewide coverage. From 2011-2013, all grantees would increase coverage by 10 percentage points annually or a minimum of 25 percent in 2011, 50 percent in 2012, and 75 percent in 2013. By 2014, when all states are fully covered by ADRCs, 12.8 million individuals would contact an ADRC for assistance. People eligible for Medicaid long-term care will likely access Medicaid funded services, including nursing facility care, state waiver services and state plan personal care and home health care, through the SEP.
- **Cost Offsets:** In order for the Single Entry Point program to cover the federal grant funds, less than one percent of the individuals screened for public nursing home or home and community-based services (approximately 4,400 out of 875,560 expected screens in 2019) who would have otherwise entered a nursing home and had Medicaid financing, instead remain in the community with Medicaid HCBS financing.[3] This should be easily achievable for the SEPs, because in its first year implementing a coordinated diversion program aimed at the critical pathway of hospital discharges in 2002 (a core function of fully functioning SEP), Indiana kept approximately five percent (1,000 individuals) of those screened for nursing facility level of care in the community. In subsequent years with less funding, they achieved 2.4 percent or approximately 500 diversions annually. Also, while the national average reduction in the number of Medicaid financed nursing home residents has been

[2] The 2007 average per ADRC operating costs are based on responses form 73 pilot sites as part of their Fall 2007 Semi-Annual Grant Reports, weighted urban/rural based on the proportion of the elderly population. The average for places with a population less than one million was $1.8 million and the average for larger populations was $6.6 million. These averages were then applied to the 655 Area Agencies on Aging at a ratio of 25 percent urban and 75 rural based on the distribution of the older population.

[3] The estimates of the total number of annual initial screens are based on a proportion of the contacts – 6.5 percent – from the experience of the nine Wisconsin ADRCs.

0.96 percent annually between 2001 and 2004, states with ADRC-like entities have had much higher reductions – Washington with an annual reduction of 2.9 percent, Wisconsin with 3.3 percent and Oregon with 4.8 percent. The cost offset is based upon the difference between average Medicaid Aged/Disabled Home and Community-Based Services (HCBS) Waiver spending[4] [adjusted upward to reflect the expected higher acuity/casemix of individuals diverted from nursing facilities][5] and the average Medicaid nursing facility spending per user.[6]

To fully fund the operating costs of the ADRCs would require approximately three percent fewer Medicaid nursing facility residents each year. In order to be conservative, offsets were calculated based on 1.5 percent diversions. To reflect the ongoing nature of existing SEPs, the offsets associated with diversion accrue 65 percent in the year of the funding and 35 percent in the following year.

- **Net Effect**: The total federal outlays over the ten year period would be $600.2 million in federal funds for a total of $800.2 million including the state match. The savings associated with the Single Entry Point total $3.0 billion ($1.7 billion federal savings and $1.3 billion state savings), with a net savings of $2.2 billion ($1.1 billion federal and $1.1 billion state).

Evidence-Based Healthy Living Program Assumptions

- **Program**: Building on the current Healthy Aging program (http://www.healthyagingprograms.org/), the Healthy Living Evidence-Based component aims to assist individuals to make behavioral changes that have proven to be effective in reducing the risk of disease and disability among the elderly. OAA providers would have flexibility to choose among Chronic Disease Self-Management Program (CDSMP), Falls Prevention, and other evidence-based programs.
    - Chronic Disease Self-Management Program (CDSMP) – A group patient education course led by specially trained lay leaders. "The program content concentrates on patients' self-defined needs and self-management options for common problems and symptoms, such as pain, fatigue, sleeping problems, anger, and depression. Patients learn skills to maximize their functioning and ability to carry out normal daily activities. … The program is based on self-efficacy theory and incorporates skill

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[4] 2002 estimates based on The Kaiser Commission on Medicaid and the Uninsured (2005), Medicaid 1915(c) Home and Community-Based Service Programs: Data Update found at http://www.kff.org/medicaid/upload/7345.pdf. For Arizona, we used data from the Arizona Health Care Cost Containment System (2002), Arizona's Community Based Services and Settings Report found at http://www.ahcccs.state.az.us/Publications/Reports/commrpt/hcbs-2002.pdf

[5] In an analysis for Wisconsin, The Lewin Group estimated that using a case mix adjusted comparable population, the cost in the community for Medicaid waiver services were 75 percent of the costs in a nursing home. "Wisconsin Family Care Final Evaluation Report" prepared for the Wisconsin Legislative Audit Bureau, June 13, 2003, pp 93-98 found at http://www.legis.state.wi.us/lab/reports/03-0FamilyCare.pdf. The HCBS waiver spending as a percent of NF spending used in the calculations here is 31.7 percent on average. The average HCBS waiver expenditures for each state were adjusted upward so that it equaled the current average plus one-half of the difference between 75% and the current average.

[6] The average annual Medicaid Nursing Facility Spending per User is a calculation based on the product of the average Medicaid Nursing Facility daily payment rate, average length of stay, and average individual contribution among Medicaid residents. The average daily rate is multiplied by 30.4 to estimate an average monthly rate. The average length of stay is a measure of the number of months during a year that a Medicaid resident stays in a nursing facility; the default value is 8 months. The default average individual contribution among Medicaid residents is 15%. Single Medicaid residents must contribute all of their personal income less a personal needs allowance (between $30 and $100 per month). For 40 states, 2007 average Medicaid NF daily rates were available from American Health Care Association, A Report on Shortfalls in Medicaid Funding for Nursing Home Care, September 2007 at http://www.ahcancal.org/research_data/funding/Documents/2007_Report_on_Shortfalls_in_Medicaid_Funding.pdf. For the remaining states we used either 2002 rates (8 states) from Grabowski et. al. (2007), Recent "Trends In State Nursing Home Payment Policies," Health Affairs web exclusive June 16, 2004 at http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.363/DC1 or 1998 rates (42 states) from Swan et. al. (2001), "State Medicaid Nursing Home Reimbursement Rates: Adjusting for Ancillaries" The Gerontologist Vol. 41, No. 5.

mastery, reinterpretation of symptoms, modeling, and social persuasion to enhance patients' sense of personal efficacy. These techniques include guided mastery of skills through weekly "action planning" and feedback on progress; modeling of self-management behaviors and problem-solving strategies; and social persuasion through group support and guidance for individual self-management efforts."[7]

- Falls Prevention – Evidence-based falls prevention programs, such as Matter of Balance. Matter of Balance is a theoretically grounded 8 session group intervention focusing on elders' fear of falling designed to achieve substantial gains in self-confidence, sense of control and reduced fear resulting in increased activity levels and quality of life for older persons. Implemented as a group course led by specially trained lay leaders.
- Other Programs – Other evidenced-based health promotion or disease prevention programs, such as physical activity.

- **Timeframe**: The funding rolls out from 2010 to 2020 at the indicated levels.
- **States Funded**: The number of states included under the funding increases from 24 in 2008 (funded under existing initiatives) to all states and territories in 2010.
- **State Match**: 15 percent of the total funding or 18 percent of the federal funding.
- **Allocation of Implementation Funding**:
  - All grantees would receive an allotment based on their relative share of the total U.S. population aged 60+, with a minimum of 0.5% of the total grant appropriation.
  - After an initial planning period, for purposes of these estimates, 43 percent of the dollars are spent on Chronic Disease Self Management, 24 percent on Matter of Balance and the remaining 33 percent would be for other programs or outreach specifically to recruit appropriate participants. The 33 percent for other programs does not have any cost offset estimates associated with those funds.
  - Budget Outlays – Due to the timing of issuing a grant solicitation and awarding funding, federal budget outlays for 2010 are expected to be 25 percent of the budget authority. In 2011, the remaining 75 percent of the 2010 funding plus 25 percent of the 2011 budget authority would become budget outlays. In subsequent years, there would be a 75 percent lag between budget authority and outlays.
- **Target Population**:
  - Chronic Disease Self-Management Program (CDSMP) -- Older Americans with chronic diseases. This population is disproportionately affected by a vast array of chronic diseases and conditions that collectively account for seven out of every 10 deaths and more than three-quarters of all health expenditures in the U.S.[8] Over 80 percent of adults 65 and over have at least one chronic condition, and roughly half suffer from two.[9] Nearly half of older adults have hypertension and roughly one in five has heart disease, with a similar proportion having some type of cancer.[10] The average 75-year old has three chronic conditions and takes 4.5 medications.[11] More than 65 percent of Americans aged 65 and over have some form of cardiovascular

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[7] Sobel, DS, Lorig, KR, Hobbs, M. Chronic Disease Self-Management Program: From Development to Dissemination. *Permanete Journal*; Spring 2002.

[8] National Center for Chronic Disease Prevention and Promotion (NCCDPHP). Physical Activity and Good Nutrition: Essential Elements to Prevent Chronic Diseases and Obesity. Available at www.cdc.gov/nccdphp/aag/aag_dnpa.htm. Accessed September 14, 2004.

[9] NCCDPHP. Healthy Aging: Preventing Disease and Improving Quality of Life Among Older Americans. Available at www.cdc.gov/nccdphp/aag/aag_aging.htm. Accessed September 14, 2004.

[10] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, National Health Interview Survey, 2000-2001.

[11] Alliance for Aging Research. Ten Reasons Why America Is Not Ready for the Coming Aging Boom. 2002.

disease. One million adults age 75+ have diabetes, a number that is expected to grow to 4 million by 2050 if nothing is done to change current growth rates.[12]

The burden of chronic diseases and conditions varies widely by race. Among adults age 65+, 65 percent of Blacks had hypertension, compared to 47% of Whites. Twenty-five percent of Hispanics have diabetes, compared to 14% of Whites.

Chronic disease exacts a heavy toll on older adults. In 2002, chronic diseases were responsible for over three-quarters of all deaths among U.S. adults over the age of 65, including heart disease (responsible for 32.4 percent of all deaths), cancer (21.7 percent), and stroke (8 percent).[13] Chronic disease not only kills, but it also negatively affects quality of life and functional status. In 1994, chronic conditions decreased the quality of life for 40 percent of elderly individuals living in community settings; 25 percent of these affected individuals were unable to perform some activities of daily living, such as bathing, shopping, dressing, or eating.[14] Nearly one third of adults over the age of 65 are disabled, compared to 18 percent of all Americans.[15] Older adults are much more likely than younger individuals to report "physically unhealthy days," with the average 18-to-24-year-old reporting 1.9 physically unhealthy days in the past month, compared to 5.2 days for the average individual aged 65 and over.[16]

- Falls Prevention – More than one third of persons 65 years of age or older fall each year,[17] and in half of such cases the falls are recurrent.[18] Factors that increase the risk of falling include side effects from medications, overall decreases in strength, gait and balance, and hazards in the home. Fear of falling is also a major risk factor for falls.[19] The program would target community dwelling cognitively intact persons age 70 and older and younger individuals who self report a fear of falling or who have fallen previously.
- Other Programs – Depends on the program, but could include frail older individuals or the broader population age 60 and over.

- **Program Costs**:
  - CDSMP program – The cost per 6 week session is estimated to be $203 in 2010. This estimate is based upon the experience of two AoA Evidence-based Prevention demonstration projects that are replicating the CDSMP and is consistent with, although slightly lower, than estimates made by Stanford and Kaiser.[20] The costs are assumed to escalate with inflation (three percent annually).[21]

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[12] NCCDPHP. Available at www.cdc.gov/nccdphp/bb_aging/index.htm. Accessed September 14, 2004.

[13] CDC, National Center for Health Statistics, National Vital Statistics Report, 2002.

[14] NCCDPHP. Available at www.cdc.gov/nccdphp/bb_aging/index.htm. Accessed September 14, 2004.

[15] CDC and Merck Institute of Aging. The State of Aging and Health in America, 2004. November 2004.

[16] CDC and Merck Institute of Aging, 2004.

[17] Hornbrook MC, Stevens VJ, Wingfield DJ, Hollis JF, Greenlick MR, Ory MG. Preventing falls among community-dwelling older persons: results from a randomized trial. *Gerontologist* 1994; 34(1):16–23.

[18] Tinetti ME, Speechley M, Ginter SF, Risk factors for falls among elderly persons living in the community. *N Engl J Med* 1988;319:1701-7.

[19] Friedman, SM, et al, 2002. "Falls and fear of falling: which comes first? A longitudinal prediction model suggests strategies for primary and secondary prevention", *Journal of the American Geriatric Society*, 50(8):1329-35.

[20] Current AoA CDSMP program cost estimate based on personal communication with the directors of the Detroit and Philadelphia sites -- $175 in 2005 inflated 3% anmually.

[21] Although these programs tend to be primarily labor intensive, we used inflation rather than wages because the Bureau of Labor Statistics' National Industry-Specific Occupational Employment and Wage Estimates for NAICS Industry 624120 - Services for the Elderly and Persons with Disabilities for social workers and social and human services assistants shows that between 2004 and 2007 wages increased at about or less than the rate of inflation.

- Falls Prevention -- The cost is assumed to be $87 per participant in 2010, based on the Matter of Balance program.[22] The costs are assumed to escalate with inflation (three percent annually).

- **Participation and Completion Rates**:
  - CDSMP program – Based on the available funding, approximately 1.8 million individuals would initiate the CDSMP over the ten year period with 75 percent completing the program, for a total of 1.3 million. The 75 percent completion rate is conservative, given that the AoA Philadelphia grant currently has 88 percent of participants completing the program.
  - Falls Prevention -- Based on the available funding, approximately 2.2 million individuals would initiate the Falls Prevention program over the ten year period with 75 percent completing the program, for a total of 1.7 million. The 75 percent completion rate is conservative because the lay leader led model of Matter of Balance being piloted in Maine is proving to be an attractive option for participants. The average attrition rate is 17 percent, generally reflecting absences due to illness or conflicting appointments. This is an improvement over the original research in which the program completion rate of health educator led programs was 63% with an additional 20% completing at least one session.[23]

- **Cost Offsets:**
  - CDSMP program – Offsets are based on the reduced hospital admissions among individuals completing the CDSMP – 0.07 fewer hospital stays.[24] In 2005, the average Medicare hospital stay payment for non-surgical stays was $5,699.[25] The literature reports reductions to total hospital admissions, not the number of people with one fewer hospital stay. Therefore, to account for the fact that those with hospital stays have more than one on average during the course of the year, we increased the per non-surgical stay estimate by a factor of 1.69 – the average number of discharges per Medicare inpatient hospital user[26] – for a total of $9,630 in 2005 and $12,292 inflated to 2010. Medical care costs were assumed to escalate at five percent annually based on the 2005 Medicare Trustees Report. As a result, the 0.07 fewer hospital stays (or approximately 12 fewer hospital stays for every 100 completers) results in $861 less in Medicare costs per completer in 2009.
  - Falls Prevention – We assumed that the program would be effective in preventing a subsequent fall for 18 percent of the 50 percent of individuals estimated to experience a subsequent fall. The 18 percent effectiveness is the same lower bound assumption used by Rand in a major study of falls prevention for CMS.[27] Offsets

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[22] Program costs based on the demonstration project with lay leaders currently implemented in Maine -- $75 in 2005 inflated 3% annually.

[23] Tennstedt, S., Howland, J., Lachman, M., Peterson, E., Kasten, L, and Jette, A. A randomized, controlled trial of a group intervention to reduce fear of falling and associated activity restriction in older adults. Journal of Gerontol: Psychological Sciences. 1998; 53D, (6): P384-P392.

[24] Sobel, DS, Lorig, KR, Hobbs, M., *Ibid.* Estimates are based on the replication effort in six Kaiser Permanete regions during 1998 that resulted in 68 CDSMP programs with 703 study participants. At one-year, 489 subjects provided information at follow-up.. Among the eight studies reviewed in http://www.healthyagingprograms.org/resources/Review_Findings_CDSMP_Outcomes1.8.08.pdf , the majority of studies showed declines -- three showed no effect on hospital stays, two studies indicated unspecified declines, and the three remaining showed 1.2-22% decline in hospital admissions. For the cost estimates, we used the middle estimate from the 1999 article that indicated a 7% decline in hospital admissions.

[25] Centers for Medicare and Medicaid Services 100% MEDPAR Inpatient Hospital National Data for Fiscal Year 2005 from the Medicare and Medicaid Statistical Supplement at http://www.cms.hhs.gov/MedicareMedicaidStatSupp/LT/list.asp#TopOfPage

[26] Ibid.

[27] RAND Report: *Evidence report and evidence-based recommendations: fall prevention interventions in the Medicare population*. Contract number 500-98-0281. RAND Corporation Southern California Evidence-Based Practice Center, 2003

are based on the reduced emergency room visits (13.6 percent of fallers) and hospital admissions (3.3 percent of fallers) among individuals who fall.[28] In 2010, the average emergency department visit was assumed to be $443 and the average payments for Medicare hospital stays related to a hip fracture or sprain (DRGs 236 and 237) was estimated at $8,382.[29] Medical care costs were assumed to escalate at five percent annually based on the 2005 Medicare Trustees Report. As a result of the reduced health care use in 2010, Medicare would have about $30 less in Medicare costs per completer ($23 per participant).

  - Other programs – A range of programs are possible and we do not know the distribution of the programs selected, therefore we did not estimate medical cost savings related to the programs.

- **Net Effect**: The total federal outlays over the ten year period would be $847.9 million in federal funds for a total of $997.6 million including the 15 percent state match. The savings associated with the CDSMP total nearly $1.4 billion and the Falls Prevention program would save $66.3 million, for a total of $1.5 billion over 10 years, all accruing to the Medicare program with a net federal savings of $665.8 million.

Nursing Home Diversion Assumptions

- **Program**: The Nursing Home Diversion program is targeted at private pay individuals. It is designed to provide an incentive for certain individuals at high functional risk of nursing home placement to stay in the community. The incentive helps to counteract the institutional bias in the system created by the Medicaid entitlement to nursing facility care by helping private pay individuals to avoid nursing facility care and spend-down to Medicaid. The Nursing Home Diversion program will be case managed through the Single Entry Points. A care plan will be developed with each client and their family caregiver. This is intended to support individuals as they arrange for ongoing support structure and funding (e.g., possibly through home equity), particularly for those in a crisis or near-crisis situation as a result of changes in functional or cognitive status, caregiver situation or an acute care health episode requiring greater assistance. Individuals targeted by intervening in critical pathways, such as prior to discharge from a hospital or initial admissions to a nursing home for post-acute care at risk of a longer term stay.
- **Timeframe**: The funding rolls out from out 2010 to 2020 at the indicated levels.
- **States Funded**: The number of states included under the funding increases from 6 in 2007 to all 50 states and the District of Columbia during this time frame. The program would be phased in with one third if the states in each year, based on readiness over three years[30].
- **State Match:** One minus the Projected Medicaid Federal Matching Assistance Percentage (FMAP) plus five percentage points (see table).

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[28] Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online] 2001, 2002 [cited 9/20/04]. Available from: www.cdc.gov/ncipc/wisqars.

[29] Similar to the CDSMP hospital estimate, the per discharge payment was increased by 1.69 to account for the multiple stays among those with hospital admissions.

[30] Current scenario uses the percent of Medicaid Long Term Care spending for HCBS Aging/Disabled Waivers as the proxy for readiness.

Federal Matching Percentage for Nursing Home Diversion Program

	2010	
	Federal Matching Percentage	**State Matching Percentage**
Alabama	73.16%	26.84%
Alaska	56.10%	43.90%
Arizona	71.24%	28.76%
Arkansas	77.84%	22.16%
California	55.00%	45.00%
Colorado	55.00%	45.00%
Connecticut	55.00%	45.00%
Delaware	55.00%	45.00%
District of Columbia	75.00%	25.00%
Florida	60.10%	39.90%
Georgia	70.24%	29.76%
Hawaii	59.08%	40.92%
Idaho	75.31%	24.69%
Illinois	55.70%	44.30%
Indiana	70.20%	29.80%
Iowa	68.16%	31.84%
Kansas	64.62%	35.38%
Kentucky	75.44%	24.56%
Louisiana	73.92%	26.08%
Maine	70.23%	29.77%
Maryland	55.00%	45.00%
Massachusetts	55.00%	45.00%
Michigan	66.69%	33.31%
Minnesota	55.00%	45.00%
Mississippi	80.42%	19.58%
Missouri	68.89%	31.11%
Montana	73.27%	26.73%
Nebraska	64.99%	35.01%
Nevada	55.00%	45.00%
New Hampshire	55.00%	45.00%
New Jersey	55.00%	45.00%
New Mexico	75.20%	24.80%
New York	55.00%	45.00%
North Carolina	70.35%	29.65%
North Dakota	68.25%	31.75%
Ohio	67.77%	32.23%
Oklahoma	70.31%	29.69%
Oregon	68.10%	31.90%
Pennsylvania	59.62%	40.38%
Rhode Island	57.60%	42.40%
South Carolina	75.43%	24.57%
South Dakota	69.71%	30.29%
Tennessee	70.58%	29.42%
Texas	63.59%	36.41%
Utah	75.86%	24.14%
Vermont	64.55%	35.45%
Virginia	55.00%	45.00%
Washington	56.35%	43.65%
West Virginia	78.63%	21.37%
Wisconsin	65.39%	34.61%
Wyoming	55.00%	45.00%

Note: Based on 2010 Medicaid Federal Matching Assistance Percentage plus five percentage points.

- **Allocation of Implementation Funding**: Funding would be allocated based on state population age 75+ between 1.5 to 3.0 times poverty. Federal funding is based on the assumption that the program would serve no more than 60 percent of potential eligibles in a given year. In 2010, the first group of states would serve 20 percent of eligibles in year 1, 40 percent in year 2, and 60 percent in year 3. Beginning in 2011, the second group of states would also have three years to reach 60 percent of eligibles. The third group of states would have five years, serving 15 percent of eligibles in 2012 and increasing by 15 percentage points annually until 2016 when all states would serve 60 percent of eligibles. The state match would be based on the Medicaid Federal Matching Assistance Percentage (FMAP) + five percentage points.
- **Target Population**: Adults 60+ who are at "high functional risk" of nursing home placement (but not eligible for Medicaid), or the OAA definition of "frail" (i.e., 2+ADLs, or 3+ at state option, and/or severe cognitive impairment) – approximately 200,000 community individuals in 2007.[31] These would be expected to be those who would enter a nursing home and spenddown to Medicaid eligibility (approximately 250,000 elderly annually).[32]
- **Program Costs**:
    - Limited amount of services (e.g., higher amount for each of the first three months – up to $2,759 in 2010 - and $662/month thereafter) or a consumer directed option. The higher initial amount permits states to stabilize a person in a community LTC setting, including housing transitions (for example, sale of house, downsizing, move to more supportive environment or location, etc.). The lower monthly amount would be expected to be supplemented by family financial or caregiving resources. Service costs are assumed to escalate 5 percent annually.
    - Budget Outlays -- Due to the timing of issuing a grant solicitation and awarding funding, federal budget outlays for 2010 are expected to be delayed 15 months. In 2011, 75 percent of the 2009 budget authority would become budget outlays. In 2012, the remaining 25 percent of the 2010 funding plus 75 percent of the 2011 budget authority would become budget outlays. In subsequent years, there would be a 15 month lag between budget authority and outlays.
- **Participation Rates**: This level of funding is expected to serve approximately 15,216 individuals or about 5.8 percent of the target population in 2011. Funding levels would increase so that by 2019 over 171,755 individuals or nearly 57 percent of the target population would be served. This assumes 60 percent of recipients receive the initial transition funding ($2,759 in 2010) for the first three months and the lower funding level ($662 in 2010) for the next five months and the remaining 40 percent receive the lower funding level for the full eight months on average.
- **Cost Offsets:** Cost offsets are dependent on the accuracy of the targeting of the benefit to individuals who would have otherwise entered a nursing home and spent down to Medicaid. In order to cover the federal funding levels, between 26 and 28 percent of those receiving the benefit the Nursing Home Diversion benefit would have otherwise had to have entered a

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[31] The target population was defined as follows: Individuals with two ore more impairments with activities of daily living and income less than 300% supplemental security income (SSI) level ($22,932 for a single individual and $34,416 for a married individual in 2008) and financial assets below $25,000. Estimates are based on the 1996 Panel of the Survey of Income and Program Participation, Wave 11 and 12 Topical modules.

[32] While spenddown in any given year is a relatively rare phenomena with only about two percent of the elderly spending down during the course of a year (750,000 individuals) among those on Medicaid, a substantial proportion end up on Medicaid by depleting their assets. The spenddown rate is higher in nursing homes than the community (between 7-10 percent versus 1.5 percent), however, seven out of ten of those spending down live in the community (half a million elderly) [Arling G, Buhaug H, Hagan S, Zimmerman D. (1991). Medicaid spenddown among nursing home residents in Wisconsin, Gerontologist 31(2):174-82; and Tempkin-Greener, Helena; Meiners, Mark R.; Petty, E; & Szydlowski, Jill (1993). Spending-down to Medicaid in the nursing home and in the community. Medical Care, Vol.30, No. 8, p. 663-679].

nursing home and spent down to Medicaid. This is based on the difference in average federal Medicaid spending for nursing facility services and other Medicaid service costs for Medicaid nursing facility residents (55% of $43,962 or $24,179 in 2009 based on Form 372 data from 2000 provided by Medstat inflated 5% annually) compared to the benefit level provided under the Nursing Home Diversion ($8,639 total or $6,479 federal). Targeting literature suggests that in well-focused programs targeted to people who exhibit potential for substitution between home and facility care and for whom the correct mix of services is provided (i.e. "home care" is not monolithic, but represents many different types of service), costs can be reduced even as HCBS is expanded. Specifically, of those screened into the Channeling control group, 41 percent had the potential for at least modest savings through the provision of HCBS.[33] Finally, an analysis of data from the 1987 National Medical Expenditure Survey (NMES) by Spector, Reschovsky and Cohen, suggests that, based on alternative criteria, at least 15 percent and as many as 70 percent of nursing home resident could be treated in lower levels of care. An important consideration is that the case mix of nursing facility residents has increased since 1987.[34] In order to be conservative, the cost offsets assume a 28 percent successful targeting.

- **Net Effect**: The total federal outlays over the ten year period would be $7.8 billion in federal funds with a total of $12.5 billion including the state match. The savings associated with the Nursing Home Diversion total $14.8 billion ($8.4 billion federal savings and $6.4 billion state savings), with a net savings of $2.3 billion ($618 million federal and $1.7 billion state).

[33] Greene, Lovely, & Ondrich (1993). The cost effectiveness of community services in a frail elderly population. *The Gerontologist, 33*: 177-189.

[34] Spector, William D., Reschovsky, James D., & Cohen, Joel W. (1996). Appropriate placement of nursing home residents in lower levels of care. *The Milbank Quarterly*, 74:139-160.

Medicaid Spenddown

Medicaid spenddown occurs when medical expenses, both acute and long term care, cause an individual to spend their financial assets down to Medicaid eligibility ($2,000 for singles and between $3,000 and $95,100 for couples where the spouse in the community of someone in a nursing home (and in some states the community) may retain half of their assets up to the larger amount plus another $2,000 for the spouse in the nursing home.

While spenddown in any given year is a relatively rare phenomena with only about two percent of the elderly spending down during the course of a year (750,000 individuals), among those on Medicaid, a substantial proportion end up on Medicaid by depleting their assets. Of the 4.5 million elderly who are Medicaid beneficiaries, 1.8 million or 40 percent spent down their assets to become eligible. While the spenddown rate is higher in nursing homes than the community (between 7-10 percent versus 1.5 percent), seven out of ten of those spending down live in the community (half a million elderly).

Spenddown happens relatively quickly in the nursing home with between one-quarter and 36 percent occurring during the first three months of a nursing home stay and one-half to three-quarters within the first year. It appears to take somewhat longer in the community with 38 percent spending down in the first year. For those that start out in the community and subsequently spenddown, the spenddown frequently results from a nursing home admission.